epicuren DISCOVERY

Professional Peel Client Form
Treatment Consent

By signing and/or initialing this form, I am confirming that I have been honest in disclosing any medical conditions I have that may affect my treatment, including, but not limited to: pregnancy, recent facial surgery or injectables, allergies, tendency to cold sores and/or fever blisters, and/or use of prescription products including, but not limited to, Retin-A®, Accutane®, Differin®, Tazorac®, or Avage®.

I understand that many variables such as age, sun damage, smoking, skin condition, and lifestyle will affect the outcome of my treatment, and that it may be necessary to receive several treatments to achieve maximum results. I acknowledge that there is no guaranteed result.

I understand that this treatment will increase skin's sensitivity to the sun and particularly the possibility of sunburn. I will apply a sunscreen with a minimum of SPF 20 daily, and avoid sun exposure and/or tanning booths immediately following this treatment and for a minimum of two weeks following this treatment.

I understand that if my skin begins to peel or flake, I am not to pull or pick at the skin; if I do, it may cause trauma or hyperpigmentation to the skin.

I understand that this is a cosmetic procedure and no medical claims are made or implied.

I understand that I may experience a slight degree of discomfort, such as stinging, itching, burning, or tightness of the skin during my treatment. However, I should immediately inform my clinician of any noticeable pain.

I understand that there is a possibility, though rare, of a complication occurring which may result in the need of medical attention. In the event of any complication, I will immediately seek medical attention, if necessary, or contact the clinician that performed the treatment for guidance.

I understand that I may or may not experience slight or noticeable peeling of the skin, but this in no way dictates the effectiveness of my treatment.

I have not had and will not have any other chemical peel, microdermabrasion, or laser treatment of any kind within 14 days BEFORE OR AFTER this treatment.

I have received a 24 hour patch test and the result is negative, or my clinician has suggested a 24 hour patch test and I have declined.

Continued Treatment Consent

Date	Initials

I certify that all of the above information is true to the best of my knowledge. I understand and agree to follow the instructions listed above. By signing this form, I waive any and all claims, damages, action and liabilities against _____
Clinician name performing professional treatment and/or business name where this professional treatment is performed
arising out of or relating to skin care services, allergic reactions to products, and/or services and health supplements suggested and/or sold.

Client Signature: _____ **Date:** _____

Clinician Signature: _____ **Date:** _____